

REGISTRATION FORM – *Pediatric Version*

(Please Print)

PATIENT INFORMATION

Patient's last name:		First:	Middle:	Marital status (circle one)		
				Single / Married / Divorced / Separated / Widowed		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	Former name (Maiden name):		Birth date:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security #:	Phone #:		
City:		State:	Zip code:		Email:	
Employer:		Employers Address:		Employment Status: FT / PT / NA	Employer phone #:	
Spouse Name:		Spouse Birth date:	Spouse Employer:		Spouse Employment Status: FT / PT / NA	
Next of Kin's Name:		Next of Kin's Address:			Next of Kin Phone #:	
Family Doctor's Name:			Referring Doctor's Name:			

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Person responsible for bill:		Birth date:	Address (if different from above):		Phone #:
Employer:	Status: FT / PT / NA	Employer address:			Employer phone #:
Primary insurance:				Effective Date:	
Insured's name:	Insured's Social Security #:	Birth date:	Policy #:	Group #:	Co-payment: \$
Patient's relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Insured's name:		Policy #:	Group #:
Patient's relationship to insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
How did you find us? (Please check one box): <input type="checkbox"/> Dr. <input type="checkbox"/> Insurance Co. <input type="checkbox"/> Hospital <input type="checkbox"/> Friend <input type="checkbox"/> Yellow Pages					
<input type="checkbox"/> Close to home/work <input type="checkbox"/> Advertisement <input type="checkbox"/> Other					

If Patient is a minor, please complete the following:

Mother's name:		Father's name:	
Mother's Address:		Father's Address:	
Mother's Phone #:		Father's Phone #:	
Mother's Employer:		Father's Employer:	
Mother's Work Phone #:		Father's Work Phone #:	

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Phone #:	Work phone #:
-----------------------------------	--------------------------	----------	---------------

This information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize LVHNN or insurance company to release any information required to process my claims.

Patient/Guardian signature	Date
----------------------------	------

Today's Date: ____/____/____

Patient Name: _____

Date of Birth: ____/____/____

Current Body Weight: _____

Height (without shoes): _____

What is your child's weight? _____

1. Health History

	Child	Family History
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol/Triglycerides	<input type="checkbox"/>	<input type="checkbox"/>
Polycystic Ovarian Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

2. Medications

Medication	Dose & Frequency

3. Weight History

What is your child's lowest weight in the past year? _____

What is your child's highest weight in the past year? _____

4. Assessment of Eating Habits and Behaviors

Do you have any concerns related to your child's eating habits? No Yes - Explain _____

Does your child follow a special diet related to their health? No Yes - Explain _____

Today's Date: ____/____/____

Patient Name: _____

Date of Birth: ____/____/____

Does your child have any food allergies or intolerances? No Yes - Explain _____

Who decides when your child is finished eating? child parent/other

What is done when your child does not want to eat all or most of the food that is on his or her plate?

What is done if your child wants seconds of a food? _____

Who prepares the family's meals and does the grocery shopping? parent/caregiver other _____

5. Food/Beverage Frequency Assessment

<p>Which of these meals or snacks did your child eat yesterday? (Check all that apply)</p> <p><input type="checkbox"/> Breakfast <input type="checkbox"/> Afternoon snack <input type="checkbox"/> Morning snack <input type="checkbox"/> Dinner/Supper <input type="checkbox"/> Lunch <input type="checkbox"/> Evening snack</p>	<p>On a typical day, how many servings of fruit does your child eat?</p> <p><input type="checkbox"/> None <input type="checkbox"/> 2 servings <input type="checkbox"/> 1 serving <input type="checkbox"/> 3 servings or more</p>
<p>Does your child skip breakfast 3 or more times per week? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does your child skip lunch 3 or more times per week? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does your child skip dinner/supper 3 or more times per week? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>On a typical day, how many servings of vegetables does your child eat? (does not include french fries, twice baked potatoes or tater tots)</p> <p><input type="checkbox"/> None <input type="checkbox"/> 2 servings <input type="checkbox"/> 1 serving <input type="checkbox"/> 3 servings or more</p>
<p>On a typical day, how many times does your child drink soda? Do not count "diet" sodas.</p> <p><input type="checkbox"/> None <input type="checkbox"/> 2 times <input type="checkbox"/> 1 time <input type="checkbox"/> 3 times or more</p>	<p>On a typical day, how many servings of cupcakes, cookies, chips, crackers, ice cream, candy or doughnuts does your child eat?</p> <p><input type="checkbox"/> None <input type="checkbox"/> 2 servings <input type="checkbox"/> 1 serving <input type="checkbox"/> 3 servings or more</p>
<p>On a typical day, how many times does your child drink sweetened beverages such as sweet tea, punch, sports drinks, fruit drinks or 100% fruit juices?</p> <p><input type="checkbox"/> None <input type="checkbox"/> 2 times <input type="checkbox"/> 1 time <input type="checkbox"/> 3 times or more</p>	<p>How many times per week does your family order in or dine out (including fast food restaurants)?</p> <p><input type="checkbox"/> None <input type="checkbox"/> 2 times <input type="checkbox"/> One time <input type="checkbox"/> 3-5 times <input type="checkbox"/> 5 or more times</p>
<p>How much soda or other sweetened beverage would your child typically drink at one time?</p> <p><input type="checkbox"/> None <input type="checkbox"/> Small glass (4-6 oz) <input type="checkbox"/> Medium glass (8-12 oz) <input type="checkbox"/> Large glass (16-20+ oz) <input type="checkbox"/> 1 can (12 oz) <input type="checkbox"/> 1 bottle (20 oz)</p>	<p>When your family dines out what does your child typically order?</p> <p><input type="checkbox"/> Hamburger/cheeseburger with fries or chips <input type="checkbox"/> Hot dog with fries or chips <input type="checkbox"/> Pizza <input type="checkbox"/> Chicken fingers and fries or chips <input type="checkbox"/> Grilled cheese and fries or chips <input type="checkbox"/> Other _____</p>
<p>On a typical day, how much water does your child drink?</p> <p><input type="checkbox"/> None <input type="checkbox"/> 2 glasses <input type="checkbox"/> 1 glass (8 oz) <input type="checkbox"/> 3 glasses or more</p>	<p>Do you feel your child eats when he/she is not hungry?</p> <p><input type="checkbox"/> Yes, several times per day <input type="checkbox"/> No <input type="checkbox"/> Unable to determine</p>

Today's Date: ____/____/____

Patient Name: _____

Date of Birth: ____/____/____

<p>On a typical day, how much milk does your child drink?</p> <input type="checkbox"/> None <input type="checkbox"/> Small glass (4-6 oz) <input type="checkbox"/> Medium glass (8-12 oz) <input type="checkbox"/> Large glass (16-20+ oz)	<p>How many times per week does your family eat meals together?</p> <input type="checkbox"/> Less than 5 <input type="checkbox"/> 5-7 times <input type="checkbox"/> 7-10 times <input type="checkbox"/> 10 or more times
<p>What type of milk does your child usually drink?</p> <input type="checkbox"/> Skim or non-fat <input type="checkbox"/> Low fat (1/2-1%) <input type="checkbox"/> Reduced fat (2%) <input type="checkbox"/> Whole <input type="checkbox"/> Flavored low fat or skim <input type="checkbox"/> Flavored whole or 2%	<p>Does your family typically eat meals and snacks in front of the television?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes

6. 24-Hour Food Recall

List all foods and beverages your child eats in one day with the approximate time. Try to give specific amounts of food eaten and tell how the food was prepared (example-1/2 cup baked potato with 1 tsp. butter).

Breakfast	Time	Lunch	Time	Dinner	Time
Snack		Snack		Snack	

7. Assessment of Activity and Sleep Habits

<p>On how many days does your child participate in physical activity for at least 20 minutes where they were sweating and breathing hard?</p> <input type="checkbox"/> None <input type="checkbox"/> 1 day or less <input type="checkbox"/> 2 days <input type="checkbox"/> 3 days <input type="checkbox"/> 4 days <input type="checkbox"/> 5 days	<p>How many hours of t.v., video games and computer time (not including homework) does your child typically spend on a weekend day?</p> <input type="checkbox"/> None <input type="checkbox"/> 1 hour or less <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 5 hours or more
<p>How many hours of t.v., video games and computer time (not including homework) does your child typically spend on a school day?</p> <input type="checkbox"/> None <input type="checkbox"/> 1 hour or less <input type="checkbox"/> 2 hours <input type="checkbox"/> 3 hours <input type="checkbox"/> 4 hours <input type="checkbox"/> 5 hours or more	<p>How many hours of sleep does your child get each night?</p> <input type="checkbox"/> 6 hours or less <input type="checkbox"/> 6-8 hours <input type="checkbox"/> 8-10 hours <input type="checkbox"/> 10 hours or more